

STATE OF MICHIGAN PROBATE COURT COUNTY CIRCUIT COURT - FAMILY DIVISION	ORDER FOR REPORT ON ALTERNATIVE TREATMENT AND REPORT	FILE NO.
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In the matter of _____, an alleged mentally ill person

ORDER

IT IS ORDERED that _____ shall prepare a report assessing the current
Name (type or print)
 availability and appropriateness for the above named individual of alternatives to hospitalization including alternatives available following an initial period of court-ordered hospitalization.

The report shall be made to the court by _____, the date of a hearing on
Date

Petition for 60 day order, discharge, etc.

Date _____ Judge _____ Bar no. _____

REPORT ON EVALUATION OF HOSPITAL TREATMENT AND/OR ALTERNATIVE PROGRAMS

1. I, _____, as _____ report as follows:
Name Profession, organization, and position

2. I have reviewed, as to their availability in or near the individual's home community, treatment resources alternative to hospitalization and report as follows: (if practical, give name of agency, program, etc.)

a. Independent mental health professional: _____

b. Community mental health day treatment, aftercare service, work activity or other program: _____

c. Substance abuse, rehabilitation service or similar program of public or private agency: _____

d. Other: _____

(PLEASE SEE OTHER SIDE)

Do not write below this line - For court use only

3. I have reviewed, as to their availability in or near the individual's home community, residential accommodations and report as follows: (If practical, give name of residence, location, etc.)

a. Independent: _____
Individual's own house, apartment, etc.

b. Residence of relative or friend: _____

c. Foster care home: _____

d. Nursing home: _____

e. Other: _____

☐ 4. The individual has been hospitalized involuntarily two or more times within the two year period immediately preceding the filing of the petition and has rejected aftercare programs and treatment.

☐ 5. I recommend release.

☐ hospitalization

☐ 6. I recommend a course of treatment of ☐ hospitalization for _____ days, followed by an alternative program

☐ an alternative program

as follows: _____

7. My recommendation is based upon the following described interviews, observations, and information:

8. I believe the hospital to which admission is proposed ☐ can ☐ cannot provide its prescribed treatment program appropriately and adequately because: _____

9. I recommend the following agency or independent mental health professional to supervise the alternative treatment:

Name

Complete address

The agency or professional ☐ has ☐ has not indicated capability and willingness to supervise the recommended program.

10. The individual currently has the following source(s) of funds to cover his or her care in the community:

☐ 11. The individual does not currently have sufficient sources of funds for community living.

☐ a. Application for supplemental funds has been made. They should be available _____.

☐ b. Application for supplemental funds has not been made because _____.

Application will be made on _____ and should be available about _____.

c. Pending receipt of supplemental funds the following funds will be available:

☐ Direct relief.

☐ CMH emergency care funds.

☐ Other assistance: _____

☐ None. Reason: _____

Date

Signature